

FILED NOV 16 1948

Registration District No. **129**

Primary Registration District No. **102**

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Home-1029 Spruce Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **None** (Specify whether)

In this community **45 Years**
years, months or days

3. (a) PRINT FULL NAME **William J. Deshler**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Etta Deshler** 6. (c) Age of husband or wife if alive **80** years

7. Birth date of deceased **Aug. 4th, 1867**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

81 **2** **21** hr. min.

9. Birthplace **Ohio**
(City, town, or county) (State or foreign country)

10. Usual occupation **Armour & Company**

11. Industry or business **Retired**

12. Name **Horace Deshler**

13. Birthplace **Ohio**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary E. Jackson**

15. Birthplace **Ohio**
(City, town, or county) (State or foreign country)

16. (a) Informant **Paul D. Deshler**

(b) Address **1029 Spruce Ave.**

17. (a) **Burial** (b) Date thereof **10/28/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Strong City, Kansas**

18. (a) Signature of funeral director **Earp & Sons**

(b) Address **4139 East 15th, St.K. C. Mo.**

19. (a) **10-27-48** (b) **Sheraldine Holmes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**

(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")

(d) Street No. **1029 Spruce Ave.**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **25**
year **1948** hour **10** minute **15** P.M.

21. I hereby certify that I attended the deceased from **June 24**, 19**48**, to **Oct. 25**, 19**48**,
that I last saw him alive on **June 24**, 19**48**,
and that death occurred on the date and hour stated above.

Immediate cause of death
Mitral regurgitation with a chronic myocarditis 5 yrs.

Due to **Nephritis, contributory cause** 2 yrs

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations **92.5**
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

James W. Graham (Specify type of place)
While at work? (a) Means of injury

23. Signature **James W. Graham** (M. D. or other)
Address **318 Argyle Bldg.** Date signed **10/26/48**

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

William H. Camp
working under my personal supervision.

, Registered Apprentice No. 241

Signed

John B. Camp
Licensed Embalmer No. 2555

P. O. Address W.C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.